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WEEKLY REPORT

American Heart Month — February 2001

February is American Heart Month. During the month, the CDC-funded New York State Department of Health cardiovascular health program and other organizations are sponsoring the Regional Cardiovascular Health Summit, which will focus on improving the quality of prevention activities in health-care systems. An estimated 12 million persons residing in the United States have coronary heart disease (CHD) (*1*), which includes myocardial infarction, angina pectoris (chest pain), or both. During 1998, approximately 460,000 persons died of CHD; 44% of these deaths were attributed to acute myocardial infarction. CHD can be prevented by reducing or controlling high cholesterol, high blood pressure, and diabetes, by abstaining from smoking, adopting a healthy diet, and engaging in moderate physical activity and weight management. Many deaths and much disability also can be prevented by early recognition of heart attack symptoms, prompt response from and transportation to an emergency department, and timely, appropriate treatment (*2*).

Many of the 25 CDC-funded state programs work with their American Heart Association affiliate and state peer review organizations to promote health system policy changes related to improving risk-reduction counseling, appropriate treatment of patients with CHD, and other prevention measures. Information about CHD warning signs, risk factors, and treatments and scientific statements on health-care quality initiatives are available on the World-Wide Web from the National Heart, Lung, and Blood Institute, http://www.nhlbi.nih.gov, the Health Care Financing Administration, http://www.hcfa.gov/quality/3y.htm, and the American Heart Association, http://www.americanheart.org*. Information about CDC-supported state cardiovascular health programs is available at http://www.cdc.gov/nccdphp.

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*References to sites of non-CDC organizations on the Internet are provided as a service to *MMWR* readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of pages found at these sites.

Mortality From Coronary Heart Disease and Acute Myocardial Infarction — United States, 1998

Despite improved clinical care, heightened public awareness, and widespread use of health innovations, coronary heart disease (CHD) remains the leading cause of death in the United States (*1,2*), and the decline in rates from CHD that began during the 1960s slowed during the 1990s (*3*). This report provides national and state-specific death rates for CHD and for acute myocardial infarction (AMI). During 2001, approximately 1.1 million persons are expected to have a CHD event (*1*). Prevention remains the key strategy for reducing CHD mortality.

National and state mortality statistics are based on information from death certificates filed in state vital statistics offices and are compiled by CDC's National Center for Health Statistics (*4*). Demographics (e.g., age and race/ethnicity) listed on death certificates are reported by funeral directors or provided by family members of the decedent. CHD deaths are those in which the underlying cause of death listed on the death certificate by a physician, medical examiner, or coroner is *International Classification of Diseases, Ninth Revision,* codes 410.0–414.9 (*5*). CHD includes AMI (410), other acute and subacute forms of ischemic heart disease (411), old myocardial infarction (412), angina pectoris (413), and other forms of chronic ischemic heart disease (414.0–414.9). Populations at risk are defined on the basis of U.S. Bureau of Census estimates of resident populations. Age-adjusted estimates are standardized to the 2000 U.S. population. Because only 0.2% of CHD deaths and 0.3% of AMI deaths occur among persons aged <35 years, the age-adjusted death rates have been limited to persons aged ≥35 years.

The annual percentage change in U.S. death rates for CHD during 1950–1959, 1960–1969, 1970–1979, 1980–1989, and 1990–1997 was 2.1, 0.2, –3.1, –3.3, and –2.7, respectively (*3*). During 1998, CHD was reported as the underlying cause of 459,841 deaths; 203,551 (44%) were attributed to AMI. During 1998, age-specific death rates per 100,000 persons increased among successive age groups for CHD and AMI. Among persons aged ≥85 years, the 1998 CHD death rate was 3743.9, which was three times higher than the rate among persons aged 75–84 years (1252.2), seven times higher than among persons aged 65–74 years (487.2), and 21 times higher than among persons aged 55–64 years (180.7) (Table 1).

The age-adjusted death rate among persons aged ≥35 years was higher among men than women (222.4 versus 135.8 per 100,000 for CHD and 99.7 versus 58.8 per 100,000 for AMI, respectively). CHD death rates were highest among white men (440.0) and second highest among black men (421.6). AMI deaths were similar among both groups (196.7 and 198.7 for white and black men, respectively) (Table 2). Compared with white men, American Indian/Alaska Native men and Asian/Pacific Islander men had much lower death rates for CHD (246.7 and 258.3, respectively) and AMI (120.9 and 109.1, respectively). Black women had the highest death rates for CHD (301.9) and AMI (140.4), followed by white (263.8 and 113.2 for CHD and AMI, respectively), American Indian/Alaska Native, (160.2 and 69.3 for CHD and AMI, respectively) and Asian/Pacific Islander (148.1 and 62.2 for CHD and AMI, respectively) women (Table 2). Compared with black and white men and women, Hispanics had lower death rates for CHD (285.4 and 189.8 for men and women, respectively) and AMI (121.6 and 76.7 for men and women, respectively) (Table 2). State variations in age-adjusted death rates for CHD and AMI ranged from 208.1 (New Mexico) to 440.6 (New York) for CHD and from 80.5 (New Mexico) to 252.6 (Arkansas) for AMI (Table 3).

Coronary Heart Disease — Continued

TABLE 1. Age-specific death rates* for coronary heart disease† and acute myocardial infarction§ — United States, 1998

Age group (yrs)	Coronary heart disease		Acute myocardial infarction	
	No.	Rate	No.	Rate
<25	160	0.2	88	0.1
25–34	936	2.4	488	1.3
35–44	6,535	14.7	3,489	7.8
45–54	20,165	58.3	11,196	32.4
55–64	40,968	180.7	22,227	98.0
65–74	89,625	487.2	43,730	237.7
75–84	149,668	1,252.2	66,288	554.6
≥85	151,765	3,743.9	56,038	1,382.4

* Per 100,000 population.
† *International Classification of Diseases, Ninth Revision*, codes 410.0–414.9.
§ Code 410.

TABLE 2. Age-adjusted death rates* for coronary heart disease† and acute myocardial infarction§ for persons aged ≥35 years, by sex and race/ethnicity — United States, 1998

Sex	Coronary heart disease		Acute myocardial infarction	
	No.	Rate	No.	Rate
Men				
White	209,457	440.0	95,617	196.7
Black	19,138	421.6	9,185	198.7
Hispanic	8,431	285.4	3,735	121.6
Asian/Pacific Islander	3,247	258.3	1,417	109.1
American Indian/Alaska Native	750	246.7	377	120.9
Women				
White	202,056	263.8	85,248	113.2
Black	21,202	301.9	9,873	140.4
Hispanic	7,602	189.8	3,102	76.7
Asian/Pacific Islander	2,259	148.1	607	62.2
American Indian/Alaska Native	617	160.2	268	69.3

* Per 100,000 population. Standardized to the 2000 U.S. Bureau of the Census population of persons aged ≥35 years.
† *International Classification of Diseases, Ninth Revision*, codes 410.0–414.9.
§ Code 410.

Reported by: Cardiovascular Health Studies Br, Div of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion; and EIS officers, CDC.

Editorial Note: An estimated 12 million persons in the United States have CHD (*3*). Of the 1.1 million persons who are expected to have a CHD event during 2001, approximately 650,000 will be first events and 450,000 will be recurrences. Each year, approximately 220,000 fatal CHD events occur suddenly among unhospitalized persons (*1*). The slowing decline in CHD death rates may be explained by the pattern of CHD risk factors reported during the 1990s (*3*). Minimal, if any, improvement has occurred in preventive behaviors (e.g., adequate physical activity, cessation of smoking, and the control of high blood pressure) (*3*). In addition, an increase has been reported in caloric consumption and the prevalence of obesity and diabetes (*3*). Factors that may have

Coronary Heart Disease — Continued

TABLE 3. Age-adjusted death rates* for coronary heart disease† and acute myocardial infarction§ among persons aged ≥35 years, by state — United States, 1998

State	Coronary heart disease		Acute myocardial infarction	
	No.	Rate	No.	Rate
Alabama	6,456	290.4	3,480	156.1
Alaska	317	212.4	136	89.5
Arizona	6,537	281.2	2,802	119.6
Arkansas	5,490	383.3	3,604	252.6
California	46,502	327.3	17,387	121.9
Colorado	3,852	235.9	1,799	109.2
Connecticut	5,443	283.9	1,887	99.3
Delaware	1,082	301.5	516	143.2
District of Columbia	711	245.9	343	118.6
Florida	35,701	347.1	13,108	128.3
Georgia	9,236	302.5	4,818	156.3
Hawaii	1,248	208.6	511	84.8
Idaho	1,570	275.6	893	156.4
Illinois	21,356	353.4	10,493	173.9
Indiana	10,840	367.9	4,820	163.3
Iowa	6,109	335.1	2,770	156.0
Kansas	4,423	301.4	2,027	140.0
Kentucky	7,335	374.5	4,282	217.6
Louisiana	6,362	318.3	3,709	184.1
Maine	2,237	321.0	990	142.7
Maryland	6,492	281.5	3,349	144.1
Massachusetts	9,780	280.3	4,271	123.3
Michigan	17,231	358.7	7,903	163.9
Minnesota	5,906	241.1	2,473	101.5
Mississippi	4,732	356.0	2,688	202.0
Missouri	12,261	407.3	6,121	205.0
Montana	1,112	231.8	478	99.7
Nebraska	2,516	262.1	968	102.8
Nevada	1,787	244.5	740	96.3
New Hampshire	1,753	308.2	698	132.1
New Jersey	15,467	355.5	6,543	150.2
New Mexico	1,596	208.1	626	80.5
New York	42,786	440.6	13,419	138.5
North Carolina	12,421	338.1	5,598	152.2
North Dakota	1,149	295.8	591	155.7
Ohio	21,904	373.5	9,130	155.5
Oklahoma	7,253	403.1	2,713	151.1
Oregon	4,657	265.4	1,818	103.7
Pennsylvania	24,587	340.8	12,145	165.2
Rhode Island	2,213	357.6	1,052	173.3
South Carolina	6,217	344.5	3,442	189.0
South Dakota	1,358	310.8	727	168.8
Tennessee	10,541	392.0	5,620	207.8
Texas	27,304	342.1	14,474	180.4
Utah	1,631	222.4	764	103.9
Vermont	818	276.6	340	115.1
Virginia	9,162	303.0	4,223	138.6
Washington	6,843	258.2	2,910	109.6
West Virginia	4,263	399.5	1,964	183.8
Wisconsin	8,918	315.3	4,444	158.5
Wyoming	661	297.7	361	161.0
Total¶	**459,841**	**337.3**	**203,551**	**149.1**

* Per 100,000 population. Standardized to the 2000 U.S. Bureau of the Census population of persons aged ≥35 years.

† *International Classification of Diseases, Ninth Revision*, codes 410.0–414.9.

§ Code 410.

¶ Total U.S. population, all ages.

Coronary Heart Disease — Continued

contributed to the racial/ethnic differences, particularly those between black and white women, include differences in CHD risk factors, case fatality rates, medical care, socioeconomic status, and state of residence (*6*).

The findings in this report are subject to at least two limitations. First, the data are subject to misclassification of race/ethnicity in the population census and on death certificates, which may result in undercounting of deaths among American Indians/Alaska Natives, Asians/Pacific Islanders, and Hispanics and overcounting of deaths among black and white populations (*7*). Second, there is no medical record verification of death certificate data on multiple-cause mortality records. The reliability and accuracy of underlying cause depends on the certifier of each death and the state and national nosologists who determine the codes and the underlying causes.

CDC funds 25 state-based cardiovascular health programs designed to prevent the first heart attack and promote a greater decline in death and disability from CHD. Measures intended to prevent a first AMI promote policy changes (e.g., health-care providers implementing American Heart Association AMI prevention guidelines) and behavioral changes that affect cardiovascular-related risk factors (e.g., high blood pressure, high cholesterol, cigarette smoking, physical inactivity, and poor nutrition). Myocardial damage, disability, and death can be forestalled if affected persons recognize AMI warning symptoms and reach medical care quickly (*8*). To reduce delays in receiving treatment (*8*) and preventing disability following a CHD event, emergency medical care often can be obtained rapidly by telephoning 911. Other interventions consist of therapeutic measures to minimize the risk for a second heart attack and subsequent heart failure (*9*), education to promote physician adherence to clinical practice guidelines, and recommendations for the appropriate treatment of CHD patients.

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Impact of the 1999 AAP/USPHS Joint Statement on Thimerosal in Vaccines on Infant Hepatitis B Vaccination Practices

On July 8,1999, the American Academy of Pediatrics (AAP) and the U.S. Public Health Service (PHS) jointly recommended reducing infant exposure to thimerosal, a commonly used vaccine preservative that contains mercury (*1,2*). Specific recommendations were made to postpone the first hepatitis B vaccine dose until 2–6 months of age for infants born to hepatitis B surface antigen (HBsAg)-negative (i.e., not hepatitis B virus [HBV]-infected) women (*1,2*). Infants born to HBsAg-positive (i.e., HBV-infected) women, or to women whose HBsAg status was unknown, were recommended to receive postexposure prophylaxis with the first dose of hepatitis B vaccine administered within 12 hours of birth (*1,2*). By mid-September 1999, when adequate supplies of preservative-free hepatitis B vaccine became available, PHS advocated a return to previous infant hepatitis B vaccination practices, including administering the first dose of hepatitis B vaccine to newborns in hospitals that had discontinued the practice (*3*). In 2000, preliminary assessments of the impact of these policy changes on routine hepatitis B vaccination practices were conducted by public health officials in Wisconsin, Oklahoma, Oregon, and Michigan. This report summarizes the results of these analyses, which indicate that many hospitals in Wisconsin have not reinstated policies to ensure routine administration of hepatitis B vaccine to newborns despite the availability of preservative-free hepatitis B vaccine, that the number of hepatitis B vaccine doses given to newborns in Oklahoma and Oregon has declined, and that an unvaccinated Michigan infant died from fulminant hepatitis B. Restoring routine newborn hepatitis B vaccination practices may require active advocacy by professional and government groups.

In Wisconsin in February 2000, the Division of Public Health mailed a survey to nurse managers of all Wisconsin birthing hospitals to assess the impact of the thimerosal statements on hepatitis B vaccination practices for newborns. Information was collected for the following periods: 1) before July 1999, 2) July–November 1999, and 3) March 2000. In Oklahoma and Oregon, data collected by previously established vaccination registries were used to assess the number of doses of hepatitis B vaccine administered to newborns before and after the publication of the thimerosal statements and after preservative-free hepatitis B vaccine became available. In Michigan, an infant death attributed to HBV was reported in January 2000, and an investigation by the Michigan Department of Community Health (MDCH) included a review of hospital and provider medical records and hospital vaccination policy changes in 1999.

Wisconsin, 1999–2000

All 110 birthing hospitals responded to the survey; 12 no longer provided obstetric services. The percentage of hospitals with written policies or standing orders for routine hepatitis B vaccination of all newborns declined from 81% before July 1999 to 10% during July–December 1999; 77% had policies or orders for routine vaccination of infants born to HBsAg-positive women during July–November 1999.

The proportion of births in hospitals where routine hepatitis B vaccination was given before discharge declined from 84% before July 1999 to 43% in March 2000. Before July 1999, 18 of 20 hospitals in southeastern Wisconsin, where 36% of HBsAg-positive pregnant women in the state resided during 1999, had written policies or standing orders to routinely provide hepatitis B vaccine to newborns. As of March 2000, five of these 18 hospitals had continued or resumed routine administration of hepatitis B vaccine to all newborns.

Thimerosal — Continued

Oklahoma and Oregon, 1999–2000

In Oklahoma and Oregon, the number of doses administered to newborns and young infants declined in July 1999 (Figure 1). In both states, the number of doses administered to newborns and young infants has not returned to pre-July 1999 levels. Among Oklahoma infants aged <1 month and Oregon infants aged <5 days, the number of hepatitis B vaccine doses administered during May–June 2000 declined 50% and 28%, respectively, compared with May–June 1999.

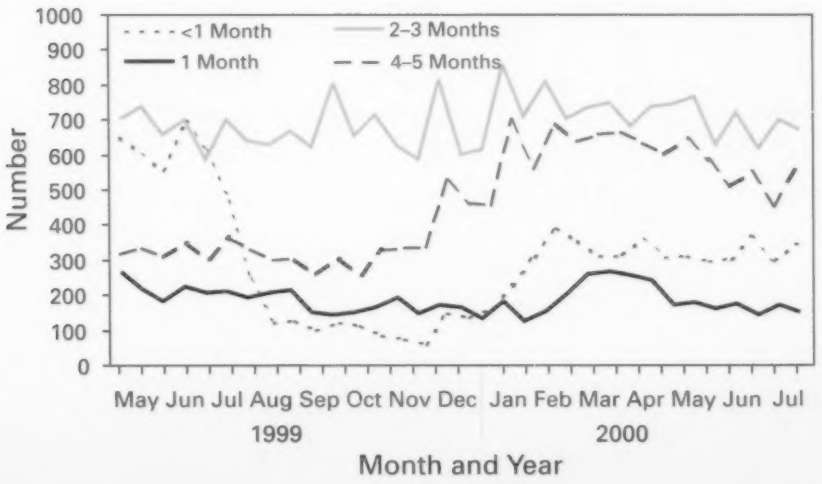
Michigan, 1999

On December 14, 1999, a previously healthy 3-month-old infant was admitted to a hospital with diarrhea and jaundice, and acute hepatic failure attributed to HBV infection was diagnosed. The infant died on December 17, 1999. The infant had not received her first dose of hepatitis B vaccine until age 2.5 months.

The infant's mother was found to be HBsAg-positive at the first of 10 prenatal visits. However, the prenatal-care record provided to the birth hospital indicated that the mother was hepatitis-negative. Neither the provider nor the laboratory reported the mother's test results to MDCH as required by law. Before July 1999, the birth hospital had routinely administered hepatitis B vaccine series to newborns before discharge but had discontinued this practice in July 1999 because of concerns about thimerosal.

Reported by: N Fasano, MA, J Blostein, MPH, Michigan Dept of Community Health. TN Saari, MD, Univ of Wisconsin, Madison; MB Hurie, MS, JP Davis, MD, Bur of Communicable Disease, Wisconsin Div of Public Health. S Dooley, ARNP, ED Rhoades, MD, Maternal and Child Health Svcs; D Blose, MA, Immunization Div, Oklahoma State Dept of Health. H Gillette, MPH, B Canavan, MPH, Immunization Program, Health Div, Oregon Dept of Human Svcs. Health Svcs Research and Evaluation Br and Program Operations Br, Div of Immunization Svcs, National Immunization Program and Hepatitis Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases, CDC.

FIGURE 1. Number of hepatitis B vaccine doses administered to infants, by age and 2-week interval — Oklahoma, May 1999–July 2000



Thimerosal — Continued

Editorial Note: The findings in this report indicate that the 1999 statements on thimerosal led to rapid changes in routine perinatal HBV infection prevention practices. Prevention of perinatal and early childhood infection by providing hepatitis B vaccine to newborns is a cornerstone of hepatitis B prevention strategies (*4*). An estimated 18,000 children aged <10 years were infected with HBV each year before universal infant hepatitis B vaccination was implemented in the United States (CDC, unpublished data, 2000). Approximately half acquired infection through perinatal transmission; the remainder acquired infection during early childhood through contact with other HBsAg-positive persons (horizontal transmission). HBV infection during infancy and childhood carries a higher risk for chronic HBV infection compared with infection during adulthood (*5,6*). Early hepatitis B vaccination is a safe and effective way to reduce the risk for both perinatal and horizontal HBV transmission and increases the likelihood of children completing the vaccine series on schedule (*7,8*).

The reported case of acute liver failure from perinatal HBV infection in Michigan underscores the problems associated with discontinuing routine hepatitis B vaccination at birth without being certain that appropriate safeguards against perinatal infection are in place. Hepatitis B vaccine administered alone is 70%–95% effective in preventing perinatal HBV infection when the first dose is given within 24 hours of birth (*4*). Results from the Wisconsin survey are consistent with results from a national survey of 1000 birthing hospitals conducted during December 1999, 3 months after thimerosal-free vaccine became widely available for infants. In this national survey, the percentage of hospitals with written policies or standing orders for routine hepatitis B vaccination of newborns born to HBsAg-negative women declined from 85% before the 1999 thimerosal statement to 34% in December 1999 (S.J. Clark, University of Michigan, personal communication, 2000). Of 88 hospitals that had discontinued written policies or standing orders for routine vaccination of newborn infants, including infants born to HBsAg-positive women, 67% had not reinstated the policies or standing orders (S.J. Clark, University of Michigan, personal communication, 2000).

It is unknown whether changes in hospital policies and reductions in hepatitis B vaccination coverage of newborns are causing other missed opportunities for vaccination among infants at high risk for perinatal infection, especially among those born to unscreened and HBsAg-positive women. The impact of the public and private health-care system response to concerns about thimerosal may not be understood fully until ongoing analysis of surveillance data and birthing hospital chart reviews provide a more complete assessment of the number of infants who acquired chronic HBV infection as the result of missed vaccination opportunities. CDC is supporting such studies in several states.

AAP and PHS advocate the reintroduction of routine hepatitis B vaccination policies for all newborn infants born in hospitals in which this practice was discontinued because of concerns about thimerosal (*3,8*). After administering a dose at birth, providers may complete the series with either 2 more doses of single antigen hepatitis B vaccine or with 3 doses of combination *Haemophilus influenzae* type b/hepatitis B vaccine according to previously recommended schedules (*9*). All birthing hospitals should have hepatitis B vaccine available for use in infants born to HBsAg-positive and unscreened women. Hospitals should continue to vaccinate all infants at birth until procedures are in place to guarantee that 1) the HBsAg status of every pregnant woman is available and reviewed at delivery, 2) appropriate passive-active immunoprophylaxis (HBIG and hepatitis B vaccine) is provided for infants of HBsAg-positive women within 12 hours of birth, and

Thimerosal — Continued

3) appropriate active immunoprophylaxis (hepatitis B vaccine) is provided for infants of women with an unknown HBsAg status. Pregnant women who are identified as HBsAg-positive should be reported to local or state health departments to ensure that their infants, family, and household contacts receive a full hepatitis B vaccination series.

Vaccination practices are influenced substantially by recommendations of professional and government advisory groups. The 1999 joint statement and the subsequent AAP guidelines were issued as a precautionary measure and were intended to apply only to infants born to HBsAg-negative women. The inadvertent effect in many hospitals was a persisting change in policies for administering hepatitis B vaccine to infants, most importantly to infants born to HBsAg-positive and unscreened women for whom no changes in vaccination practices had been recommended. Changes in established recommendations, especially if they occur without timely communication and education of health-care providers, may result in misinterpretation and unanticipated changes in vaccination practices.

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Notice to Readers

Risk for Meningococcal Disease Associated With the Hajj 2001

Every year approximately two million pilgrims from more than 140 countries gather in Saudi Arabia for a pilgrimage to the holy places of Islam known as the Hajj. Coinciding with the Hajj pilgrimage during March 2000, Saudi Arabian health officials identified an outbreak of meningococcal disease; a substantial proportion of the isolates were the bacterial strain *Neisseria meningitidis* serogroup W-135. Four cases of meningococcal disease subsequently were identified among the estimated 15,000 pilgrims returning to the United States, their close contacts, and community. In addition, approximately 400 cases of meningococcal disease caused by *N. meningitidis* serogroup W-135 were

Notices to Readers — Continued

identified worldwide during 2000 (*1*). Whether an outbreak of meningococcal disease will recur in 2001 is unknown.

Following an outbreak of serogroup A meningococcal disease associated with the Hajj during 1987, the Saudi Arabian government required all pilgrims to receive the meningococcal polysaccharide vaccine (*2*). In the United States, the available vaccine, quadrivalent meningococcal polysaccharide vaccine, contains serogroup W-135 polysaccharide. However, vaccination does not protect against asymptomatic nasopharyngeal carriage of the bacteria. Persons may transmit *N. meningitidis* infection to close contacts upon their return from Saudi Arabia, and taking an antibiotic can reduce the risk for transmission and disease. It is not known whether returning pilgrims will have increased rates of acquisition of nasopharyngeal carriage of *N. meningitidis*.

To assess the risk for meningococcal disease in returning pilgrims and their close contacts, CDC is planning to evaluate nasopharyngeal carriage among a set of pilgrims returning from the Hajj. The results of this evaluation and any recommendations will be posted on the World-Wide Web, http://www.cdc.gov/travel, when they become available. Information also will be available by telephone, (888) 232-3228.

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Notice to Readers

Publication of Report on Indicators for Chronic Disease Surveillance

In 1999, the Council of State and Territorial Epidemiologists (CSTE) released its first report on "Indicators for Chronic Disease Surveillance: Consensus of the Council of State and Territorial Epidemiologists (CSTE), Association of State and Territorial Chronic Disease Program Directors (ASTCDPD), and Centers for Disease Control and Prevention (CDC)." The document was the result of a consensus involving epidemiologists and program directors at the state and federal level. The 73 selected indicators serve as measures that states and territories can use to uniformly define, collect, and report chronic disease data.

CSTE has updated this volume with a few minor changes, and it is available in an electronic format for downloading at http://www.cste.org/resources.htm. Also available online on this site is the data volume that complements the case definitions, with data points for each state and each of the indicators.

CSTE intends to review and revise the indicators every several years and started the revision process at the 2000 National Conference on Chronic Disease Prevention. Other plans include developing a web-based system to view data by region, indicator, and prevention pathway.

Notices to Readers — Continued

Notice to Readers

Epidemiology in Action

CDC and Rollins School of Public Health at Emory University will co-sponsor a course, "Epidemiology in Action" during April 30–May 11, 2001, at CDC and Emory University campuses. The course is designed for state and local public health professionals.

The course will emphasize the practical application of epidemiology to public health problems and will consist of lectures, workshops, classroom exercises (including actual epidemiologic problems), and roundtable discussions. Topics covered will include descriptive epidemiology and biostatistics, analytic epidemiology, epidemic investigations, public health surveillance, surveys and sampling, Epi Info 2000 (Windows version) training, and discussions of selected prevalent diseases. There is a tuition charge.

Deadline for application is March 1, 2001. Additional information and applications are available from Emory University, International Health Dept.(PIA), 1518 Clifton Road, N.E., Room 746, Atlanta, GA 30322; telephone (404) 727-3485; fax (404) 727-4590; World-Wide Web site, http://www.sph.emory.edu/EPICOURSES; or e-mail pvaleri@sph.emory.edu.

Notice to Readers

Satellite Broadcast on Epidemiology and Prevention of Vaccine-Preventable Diseases

CDC's National Immunization Program (NIP) and the Public Health Training Network (PHTN) will co-sponsor a live satellite broadcast for physicians, nurses, nurse practitioners, physician assistants, pharmacists, residents, medical and nursing students, and their colleagues who either give vaccinations or set policy in their workplace. The four-part series, "Epidemiology and Prevention of Vaccine-Preventable Diseases," will be broadcast on March 15, 22, and 29, and April 5, 2001, from noon to 3:30 p.m. eastern time.

The program will provide the most current information in the field of immunization. Session one will cover principles of vaccination, general recommendations on vaccination, and strategies to improve vaccination coverage levels; session two will cover pertussis, pneumococcal disease (childhood), poliomyelitis, and *Haemophilus influenzae type b*; session three will cover measles, rubella, varicella, and vaccine safety; and session four will focus on hepatitis B, hepatitis A, influenza, and pneumococcal disease (adult).

Participants will be able to interact with instructors through toll-free telephone, fax, and TTY lines. Continuing education for various professions will be offered based on 14 hours of instruction.

Information and registration are available through state or county health department immunization programs. A list of state immunization coordinators is available on the NIP World-Wide Web site, http://www.cdc.gov/nip/ed/coordinators.htm. Course participants will be required to obtain their own copy of the primary course text, *Epidemiology and Prevention of Vaccine-Preventable Diseases*, 6th edition (2000). The text is available from the Public Health Foundation for $25; telephone (877) 252-1200; World-Wide Web site, http://bookstore.phf.org. All other course materials will be provided on site.

Notices to Readers — Continued

Notice to Readers

2001 Cancer Conference

CDC's 2001 Cancer Conference will be held September 4–7, 2001, in Atlanta, Georgia. The theme is "Using Science to Build Comprehensive Cancer Programs: A 2001 Odyssey." Co-sponsors are the American Cancer Society National Home Office, the Association of State and Territorial Chronic Disease Program Directors, and the National Cancer Institute. The conference will explore evidence-based science and how it applies in a public health setting. Short courses will be held September 4 as part of the preconference activities. The conference will assist participants in the following: 1) applying current scientific thinking to cancer prevention, early detection, diagnosis and treatment, and rehabilitation and palliation for breast, cervical, colorectal, lung, oral, ovarian, prostate, and skin cancers, and tobacco control; 2) increasing research and evaluation in communities and among populations to broaden the use of science as the basis for decision-making, policy development, program management, and implementation; 3) enhancing surveillance systems, with new and existing data, to develop cancer prevention and control program activities; 4) incorporating evidence-based approaches to improve the delivery of public health interventions for all populations in the United States; 5) using advances in medicine, communications, education, and technology to improve cancer prevention and early detection efforts; and 6) developing and applying strategies for an integrated and coordinated approach to reduce morbidity and mortality from cancer.

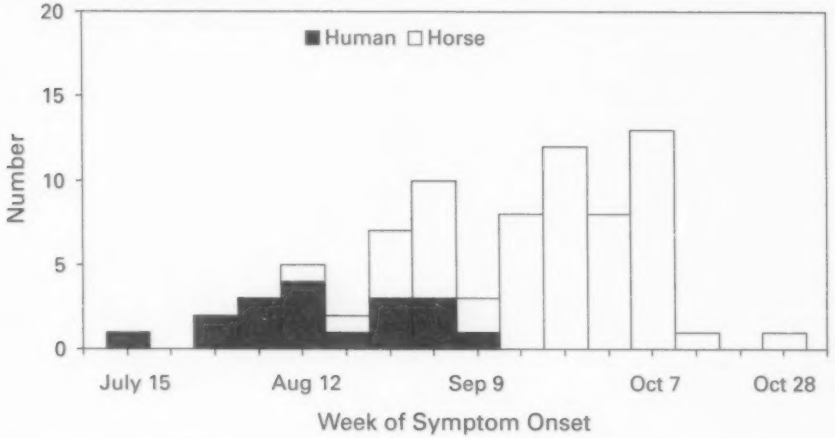
Continuing education credit will be offered for physicians, registered nurses, health educators, and cancer registrars based on 19.5 hours of instruction. The Call for Abstracts and Conference Registration Booklet is now available. Deadline for abstract submission is March 19, 2001. New this year is a Cyber Expo for showcasing innovative public health Internet sites and CD-ROM-based products. Registration information is available at http://www.cdc.gov/cancer/conference2001; deadline for registration is June 27, 2001.

Erratum: Vol. 49, No. 46

In the article, "Update: West Nile Virus Activity—Eastern United States, 2000," on page 1045, the number of West Nile virus-infected horses with neurologic disease from New York was incorrect. The correct number is 17.The total number of infected horses in the United States for 2000 with neurologic signs is 58, with the dates of illness ranging from August 17 to October 29 (Figure 1).

Notices to Readers — Continued

FIGURE 1. Number* of reported humans and horses with severe neurologic illness attributed to West Nile virus, by week of symptom onset — United States, 2000



*n=18 humans and 58 horses.

Erratum: Vol. 50, No. 4

In the article, "Injection Practices Among Nurses—Vâlcea, Romania, 1998," on page 61, the name of the first author in reference 1 was misspelled. The correct spelling is *Hersh BS.*

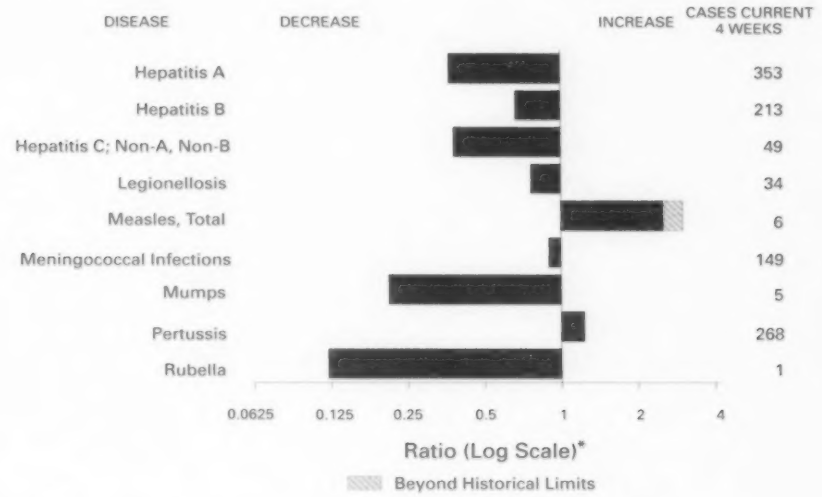
Addendum: Vol. 49, No. 50

In the article, "Multistate Outbreak of Listeriosis—United States, 2000," on page 1129, a credit was missing in the "Reported by" section: *D Schoonmaker-Bopp,* Wadsworth Center, New York Dept of Health.

Addendum: Vol. 50, No. 3

In the article, "Serosurveys for West Nile Virus Infection—New York and Connecticut Counties, 2000," on page 38, the following credits should be added to the "Reported by" section: *F Schwarz, MS, A Szlakowicz, MA, E Nadel, PhD, Suffolk County Dept of Health Svcs; and Public Health Prevention Svc Prevention Specialists, CDC.*

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending February 10, 2001, with historical data



* Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending February 10, 2001 (6th Week)

	Cum. 2001		Cum. 2001
Anthrax	-	Poliomyelitis, paralytic	-
Brucellosis*	-	Psittacosis*	2
Cholera	-	Q fever*	1
Cyclosporiasis*	-	Rabies, human	-
Diphtheria	-	Rocky Mountain spotted fever (RMSF)	6
Ehrlichiosis: human granulocytic (HGE)*	3	Rubella, congenital syndrome	-
human monocytic (HME)*	1	Streptococcal disease, invasive, group A	216
Encephalitis: California serogroup viral*	-	Streptococcal toxic-shock syndrome*	9
eastern equine*	-	Syphilis, congenital†	-
St. Louis*	-	Tetanus	1
western equine*	-	Toxic-shock syndrome	10
Hansen disease (leprosy)*	-	Trichinosis	2
Hantavirus pulmonary syndrome*†	-	Tularemia*	1
Hemolytic uremic syndrome, postdiarrheal*	3	Typhoid fever	9
HIV infection, pediatric*†	10	Yellow fever	-
Plague	-		

-: No reported cases.
*Not notifiable in all states.
† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (NCID).
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update January 30, 2001.
¶ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending February 10, 2001, and February 12, 2000 (6th Week)

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7*			
							NETSS		PHLIS	
	Cum. 2001§	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	2,792	2,720	52,163	70,192	82	102	76	157	44	125
NEW ENGLAND	91	283	1,721	2,627	5	3	10	12	3	15
Maine	3	3	-	157	-	1	-	1	-	1
N.H.	5	4	102	119	-	-	3	3	1	3
Vt.	5	-	79	64	2	1	-	1	-	2
Mass.	51	228	1,045	1,117	-	1	7	3	2	3
R.I.	11	6	369	279	1	-	-	-	-	-
Conn.	16	42	126	891	2	-	-	4	-	6
MID. ATLANTIC	555	796	2,000	6,605	5	9	9	23	4	34
Upstate N.Y.	4	21	N	N	3	4	9	21	4	28
N.Y. City	360	495	633	2,765	2	4	-	1	-	-
N.J.	157	195	225	1,450	-	-	-	1	-	2
Pa.	34	85	1,142	2,390	-	1	N	N	-	4
E.N. CENTRAL	224	141	7,801	13,064	26	26	16	26	11	5
Ohio	46	24	200	3,582	12	5	10	4	6	2
Ind.	26	26	1,428	1,419	7	3	3	1	-	1
Ill.	121	63	1,993	3,902	-	4	3	11	3	-
Mich.	23	19	3,327	2,329	7	3	-	6	-	1
Wis.	8	9	853	1,832	-	11	-	4	2	1
W.N. CENTRAL	44	47	2,165	4,135	3	1	11	30	7	26
Minn.	12	11	562	953	-	-	3	3	2	11
Iowa	9	7	202	189	1	-	-	3	-	3
Mo.	7	15	352	1,613	-	-	6	19	2	7
N. Dak.	-	-	-	95	-	1	-	1	-	1
S. Dak.	-	1	226	174	-	-	1	-	1	-
Nebr.	6	4	124	372	2	-	-	2	-	3
Kans.	10	9	699	739	-	-	1	2	2	1
S. ATLANTIC	734	578	10,677	12,621	13	10	9	14	2	14
Del.	15	15	331	338	-	-	-	-	-	-
Md.	41	92	1,282	1,182	2	1	-	4	-	1
D.C.	62	23	307	278	1	-	-	-	U	U
Va.	48	41	1,498	1,301	2	-	1	3	1	4
W. Va.	6	4	198	222	-	-	-	1	-	1
N.C.	57	27	1,654	1,627	2	2	6	4	1	1
S.C.	61	34	1,065	2,065	-	-	1	-	-	-
Ga.	104	97	1,561	2,827	-	3	-	1	-	3
Fla.	340	245	2,781	2,781	6	4	1	1	-	4
E.S. CENTRAL	148	140	5,026	4,049	3	4	3	5	3	3
Ky.	18	20	948	826	-	-	-	2	2	-
Tenn.	80	35	1,744	1,409	-	-	2	2	1	3
Ala.	25	50	1,213	1,099	2	4	1	1	-	-
Miss.	25	35	1,121	715	1	-	-	-	-	-
W.S. CENTRAL	409	267	10,474	11,351	2	5	2	9	8	13
Ark.	19	8	1,069	416	1	1	-	2	-	1
La.	130	44	2,001	1,847	-	-	-	-	5	5
Okla.	20	10	1,231	1,039	1	-	2	3	2	3
Tex.	240	205	6,173	8,049	-	4	-	4	1	4
MOUNTAIN	145	100	2,641	4,058	6	7	5	18	5	6
Mont.	1	1	42	110	-	-	-	5	-	-
Idaho	-	3	206	228	1	1	2	1	-	-
Wyo.	-	1	69	81	-	-	-	2	-	2
Colo.	38	33	160	1,011	-	2	1	6	2	1
N. Mex.	7	8	580	513	3	-	-	-	-	-
Ariz.	52	21	1,146	1,330	1	2	2	2	2	2
Utah	11	12	67	320	1	2	-	1	1	1
Nev.	36	21	371	465	-	-	-	1	-	-
PACIFIC	442	368	9,658	11,682	19	37	11	20	1	9
Wash.	26	46	1,600	1,523	N	U	2	1	-	3
Oreg.	17	11	592	374	5	1	2	3	1	3
Calif.	398	302	6,930	9,128	14	36	7	12	-	-
Alaska	1	-	200	248	-	-	-	-	-	-
Hawaii	-	9	336	409	-	-	-	4	-	3
Guam	2	-	-	-	-	-	N	N	U	U
P.R.	48	75	382	U	-	-	-	-	U	U
V.I.	1	-	U	U	U	U	U	U	U	U
Amer. Samoa	-	-	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

† Chlamydia refers to genital infections caused by *C. trachomatis*. Totals reported to the Division of STD Prevention, NCHSTP.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update January 30, 2001.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 10, 2001, and February 12, 2000 (6th Week)

Reporting Area	Gonorrhea		Hepatitis C; Non-A, Non-B		Legionellosis		Listeriosis	Lyme Disease	
	Cum. 2001[1]	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	26,141	37,807	98	413	45	67	21	174	333
NEW ENGLAND	495	848	1	1	1	5	4	41	36
Maine	-	8	-	-	-	2	-	-	-
N.H.	11	12	-	-	-	-	-	37	11
Vt.	14	1	1	-	1	-	-	-	-
Mass.	331	334	-	1	-	3	3	1	11
R.I.	95	68	-	-	-	-	-	-	-
Conn.	44	425	-	-	-	-	1	3	14
MID. ATLANTIC	1,428	3,555	6	65	1	4	1	85	234
Upstate N.Y.	443	275	3	-	1	2	1	63	56
N.Y. City	313	1,150	-	-	-	-	-	-	11
N.J.	140	825	-	60	-	-	-	-	40
Pa.	532	1,305	3	5	-	2	-	22	127
E.N. CENTRAL	4,081	8,032	17	37	24	25	4	8	5
Ohio	137	2,101	1	-	13	11	1	8	1
Ind.	660	680	-	-	3	2	-	-	-
Ill.	893	2,791	-	5	-	2	-	-	1
Mich.	2,048	1,628	16	32	8	5	3	-	-
Wis.	343	832	-	-	-	5	-	U	3
W.N. CENTRAL	885	1,766	30	50	5	3	1	3	7
Minn.	191	366	-	-	-	1	-	3	1
Iowa	64	56	-	-	-	1	-	-	-
Mo.	246	873	29	49	3	1	-	-	2
N. Dak.	-	3	-	-	-	-	-	-	-
S. Dak.	27	21	-	-	-	-	-	-	-
Nebr.	31	125	-	-	1	-	-	-	-
Kans.	326	322	1	1	1	-	1	-	4
S. ATLANTIC	7,344	10,633	6	5	5	17	3	27	40
Del.	174	184	-	-	-	1	-	-	5
Md.	772	832	3	1	4	7	1	24	30
D.C.	310	288	-	-	-	-	-	1	-
Va.	941	1,120	-	-	1	2	1	1	-
W. Va.	35	69	-	-	N	N	-	-	2
N.C.	1,439	1,332	1	3	-	1	-	1	3
S.C.	1,209	2,767	-	-	-	2	-	-	-
Ga.	808	1,860	-	-	-	-	1	-	-
Fla.	1,656	2,181	2	1	-	4	-	-	-
E.S. CENTRAL	3,483	3,146	20	65	3	1	4	2	-
Ky.	410	379	-	4	2	-	1	2	-
Tenn.	1,233	1,164	5	12	-	-	2	-	-
Ala.	1,060	927	-	3	1	1	1	-	-
Miss.	780	676	15	46	-	-	-	-	-
W.S. CENTRAL	5,586	6,249	2	132	1	4	-	-	2
Ark.	770	255	1	-	-	-	-	-	-
La.	1,442	1,487	1	71	1	2	-	-	2
Okla.	603	504	-	-	-	-	-	-	-
Tex.	2,771	4,003	-	61	-	2	-	-	-
MOUNTAIN	794	1,151	6	31	-	4	-	-	-
Mont.	2	-	-	-	-	-	-	-	-
Idaho	13	15	-	-	-	1	-	-	-
Wyo.	9	5	2	20	-	-	-	-	-
Colo.	200	431	1	5	-	2	-	-	-
N. Mex.	116	92	3	3	-	-	-	-	-
Ariz.	322	388	-	3	-	-	-	-	-
Utah	9	49	-	-	-	1	-	-	-
Nev.	123	171	-	-	-	-	-	-	-
PACIFIC	2,045	2,427	10	27	5	4	4	8	9
Wash.	379	295	-	2	1	1	-	-	-
Oreg.	114	47	2	7	N	N	1	1	1
Calif.	1,474	2,006	8	18	4	3	3	7	8
Alaska	23	24	-	-	-	-	-	-	-
Hawaii	55	55	-	-	-	-	-	N	N
Guam	-	-	-	-	-	-	-	-	-
P.R.	87	59	-	1	2	-	-	N	N
V.I.	U	U	U	U	U	U	-	U	U
Amer. Samoa	U	U	U	U	U	U	-	U	U
C.N.M.I.	U	U	U	U	U	U	-	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 10, 2001, and February 12, 2000 (6th Week)

Reporting Area	Malaria		Rabies, Animal		Salmonellosis*			
					NETSS		PHLIS	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	73	89	331	427	1,580	2,596	1,254	2,398
NEW ENGLAND	8	2	51	48	154	155	70	178
Maine	-	-	10	11	8	9	5	9
N.H.	-	-	1	1	12	10	7	8
Vt.	-	-	9	3	8	3	7	3
Mass.	2	2	13	20	93	107	15	110
R.I.	-	-	7	2	9	3	11	13
Conn.	6	-	11	11	24	23	25	35
MID. ATLANTIC	3	14	65	66	116	360	176	414
Upstate N.Y.	1	5	52	52	52	43	31	93
N.Y. City	2	6	U	U	45	110	96	124
N.J.	-	2	13	6	-	145	15	77
Pa.	-	1	-	8	19	62	34	120
E.N. CENTRAL	21	11	3	5	242	380	268	196
Ohio	4	2	-	1	104	94	73	73
Ind.	6	-	1	-	21	25	19	39
Ill.	-	5	-	-	64	130	100	-
Mich.	11	4	2	-	53	55	50	57
Wis.	-	-	-	4	-	76	26	27
W.N. CENTRAL	1	6	33	43	124	123	88	124
Minn.	-	2	11	15	29	19	39	40
Iowa	-	-	10	4	14	11	1	10
Mo.	1	1	2	2	42	44	36	34
N. Dak.	-	-	-	2	-	2	1	4
S. Dak.	-	-	6	12	13	6	4	8
Nebr.	-	-	-	-	9	16	-	12
Kans.	-	3	4	8	17	25	7	16
S. ATLANTIC	20	24	128	142	416	397	250	387
Del.	1	-	-	6	11	8	5	9
Md.	9	15	31	30	64	81	50	60
D.C.	2	-	-	-	11	-	U	U
Va.	6	7	33	40	56	39	18	46
W. Va.	-	-	8	11	1	14	9	9
N.C.	1	2	35	39	107	93	45	67
S.C.	-	-	7	9	49	46	19	37
Ga.	-	-	-	-	28	49	104	125
Fla.	1	-	14	7	89	67	-	34
E.S. CENTRAL	1	4	1	17	150	145	39	104
Ky.	-	1	-	2	31	22	17	17
Tenn.	1	-	1	12	28	30	19	51
Ala.	-	3	-	3	71	52	-	29
Miss.	-	-	-	-	20	41	3	7
W.S. CENTRAL	1	1	9	73	34	229	131	271
Ark.	-	-	-	-	23	17	13	19
La.	1	1	-	-	4	35	39	51
Okla.	-	-	9	7	7	17	8	20
Tex.	-	-	-	66	-	160	71	181
MOUNTAIN	2	6	14	15	93	231	92	187
Mont.	1	-	4	6	7	11	-	-
Idaho	1	-	-	-	5	18	4	11
Wyo.	-	-	-	7	3	3	1	1
Colo.	-	2	-	-	1	47	30	38
N. Mex.	-	-	-	-	23	21	10	23
Ariz.	-	2	10	2	31	70	30	75
Utah	-	2	-	-	12	42	17	39
Nev.	-	-	-	-	11	19	-	-
PACIFIC	16	21	27	18	251	576	140	537
Wash.	-	-	-	-	13	9	-	65
Oreg.	4	3	-	-	29	38	21	47
Calif.	11	17	12	16	205	489	85	392
Alaska	1	-	15	2	4	8	-	9
Hawaii	-	1	-	-	-	32	34	24
Guam	-	-	-	-	-	-	U	U
P.R.	-	2	7	6	5	24	U	U
V.I.	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 10, 2001, and February 12, 2000 (6th Week)

Reporting Area	Shigellosis* NETSS Cum. 2001	Shigellosis* NETSS Cum. 2000	Shigellosis* PHLIS Cum. 2001	Shigellosis* PHLIS Cum. 2000	Syphilis (Primary & Secondary) Cum. 2001	Syphilis (Primary & Secondary) Cum. 2000	Tuberculosis Cum. 2001	Tuberculosis Cum. 2000
UNITED STATES	805	1,464	481	886	455	676	409	851
NEW ENGLAND	15	45	6	29	4	7	18	20
Maine	-	2	-	-	-	-	-	-
N.H.	-	1	-	-	-	-	-	-
Vt.	-	-	-	-	-	-	-	-
Mass.	12	35	1	20	3	5	13	9
R.I.	-	2	-	4	-	1	-	2
Conn.	3	5	5	5	1	1	5	9
MID. ATLANTIC	82	85	59	85	21	26	48	104
Upstate N.Y.	52	14	2	12	1	-	-	7
N.Y. City	22	35	39	28	13	15	-	61
N.J.	-	29	2	19	4	6	32	29
Pa.	8	7	16	26	3	5	16	7
E.N. CENTRAL	158	274	93	91	48	147	70	82
Ohio	52	14	20	3	2	11	12	13
Ind.	26	17	5	8	12	50	10	2
Ill.	38	118	48	-	8	52	40	64
Mich.	42	102	18	78	25	23	-	-
Wis.	-	23	2	2	1	11	8	3
W.N. CENTRAL	146	61	108	62	-	15	20	28
Minn.	64	11	74	29	-	3	13	14
Iowa	16	11	-	12	-	-	-	-
Mo.	42	31	29	14	-	10	5	11
N. Dak.	-	-	1	-	-	-	-	-
S. Dak.	1	1	-	-	-	-	1	-
Nebr.	8	4	-	4	-	1	1	1
Kans.	15	3	4	3	-	1	-	2
S. ATLANTIC	109	93	46	41	163	210	67	99
Del.	1	-	-	-	-	1	-	-
Md.	14	10	2	3	20	38	7	8
D.C.	5	-	U	U	3	12	9	-
Va.	10	9	3	10	12	17	-	-
W. Va.	1	-	4	-	-	-	4	5
N.C.	32	8	19	5	50	60	7	9
S.C.	12	3	7	1	26	15	8	18
Ga.	3	5	10	16	13	24	32	33
Fla.	31	58	1	6	39	43	-	26
E.S. CENTRAL	82	76	23	39	100	88	28	59
Ky.	38	14	12	6	5	3	-	4
Tenn.	6	31	9	30	27	62	-	19
Ala.	21	5	-	1	18	15	24	27
Miss.	17	26	2	2	50	8	4	9
W.S. CENTRAL	24	249	91	266	72	106	13	180
Ark.	18	18	10	3	8	3	13	8
La.	3	39	19	18	14	19	-	1
Okla.	2	4	-	4	10	32	-	5
Tex.	1	188	62	241	40	52	-	166
MOUNTAIN	53	156	41	58	19	20	8	44
Mont.	-	-	-	-	-	-	-	-
Idaho	2	15	-	12	-	-	-	-
Wyo.	-	-	-	-	-	-	-	-
Colo.	2	25	10	12	1	-	5	4
N. Mex.	18	17	7	12	1	-	1	4
Ariz.	25	60	21	17	12	18	2	12
Utah	1	5	3	5	4	-	-	4
Nev.	5	34	-	-	1	2	-	20
PACIFIC	136	425	14	215	28	57	137	235
Wash.	19	57	-	170	12	4	18	16
Oreg.	14	67	14	40	2	-	-	1
Calif.	103	292	-	-	12	53	113	209
Alaska	-	2	-	1	-	-	6	1
Hawaii	-	7	-	4	2	-	-	8
Guam	-	-	U	U	-	-	-	-
P.R.	-	3	U	U	27	23	-	-
V.I.	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.

*Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending February 10, 2001, and February 12, 2000 (6th Week)

Reporting Area	*H. influenzae*, Invasive		Hepatitis (Viral), By Type				Measles (Rubeola)					
			A		B		Indigenous		Imported*		Total	
	Cum. 2001†	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	2001	Cum. 2001	2001	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	103	146	587	1,426	356	609	1	5	-	2	7	4
NEW ENGLAND	4	13	33	34	4	14	-	-	-	-	-	-
Maine	-	-	1	1	1	1	-	-	-	-	-	-
N.H.	-	1	3	5	2	3	-	-	-	-	-	-
Vt.	-	2	-	1	-	2	-	-	-	-	-	-
Mass.	4	10	8	13	1	1	-	-	-	-	-	-
R.I.	-	-	2	-	-	-	-	-	-	-	-	-
Conn.	-	-	19	14	-	7	-	-	-	-	-	-
MID. ATLANTIC	15	21	33	86	31	102	-	-	-	-	-	1
Upstate N.Y.	5	10	15	26	5	6	-	-	-	-	-	-
N.Y. City	5	7	15	50	20	62	-	-	-	-	-	1
N.J.	4	3	-	3	-	6	-	-	-	-	-	-
Pa.	1	1	3	7	6	28	-	-	-	-	-	-
E.N. CENTRAL	13	22	96	231	68	70	-	-	-	-	-	1
Ohio	9	8	28	52	12	13	-	-	-	-	-	-
Ind.	3	2	2	4	2	1	-	-	-	-	-	-
Ill.	-	10	13	98	2	1	-	-	-	-	-	-
Mich.	1	2	53	65	52	54	-	-	-	-	-	1
Wis.	-	-	-	12	-	1	-	-	-	-	-	-
W.N. CENTRAL	2	3	53	141	21	38	1	1	-	-	1	-
Minn.	-	-	1	12	-	-	-	-	-	-	-	-
Iowa	-	-	3	10	-	7	-	-	-	-	-	-
Mo.	2	3	10	100	16	27	-	-	-	-	-	-
N. Dak.	-	-	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	1	-	-	-	-	-	-	-
Nebr.	-	-	15	3	4	2	-	-	-	-	-	-
Kans.	-	-	24	16	-	2	1	1	-	-	1	-
S. ATLANTIC	34	37	92	84	60	69	-	2	-	1	3	-
Del.	-	-	-	-	-	-	-	-	-	-	-	-
Md.	7	19	32	19	11	20	-	2	-	1	3	-
D.C.	-	-	3	-	2	-	-	-	-	-	-	-
Va.	3	8	14	15	9	15	-	-	-	-	-	-
W. Va.	1	1	-	7	-	-	U	-	U	-	-	-
N.C.	6	3	5	21	26	21	-	-	-	-	-	-
S.C.	1	1	9	1	-	1	-	-	-	-	-	-
Ga.	7	4	-	4	1	-	-	-	-	-	-	-
Fla.	9	1	29	17	11	12	-	-	-	-	-	-
E.S. CENTRAL	1	4	25	71	24	53	-	-	-	-	-	-
Ky.	-	1	2	4	2	7	-	-	-	-	-	-
Tenn.	-	3	13	21	5	22	-	-	-	-	-	-
Ala.	1	-	10	9	9	3	-	-	-	-	-	-
Miss.	-	-	-	37	8	21	-	-	-	-	-	-
W.S. CENTRAL	1	12	37	281	19	71	-	-	-	-	-	-
Ark.	-	-	13	13	11	7	-	-	-	-	-	-
La.	-	4	5	12	1	25	-	-	-	-	-	-
Okla.	1	8	19	40	7	5	-	-	-	-	-	-
Tex.	-	-	-	216	-	34	-	-	-	-	-	-
MOUNTAIN	26	20	74	96	26	46	-	-	-	1	1	-
Mont.	-	-	2	1	-	1	-	-	-	-	-	-
Idaho	-	1	-	3	-	3	-	-	-	1	1	-
Wyo.	-	-	1	-	-	-	-	-	-	-	-	-
Colo.	-	5	1	28	-	14	-	-	-	-	-	-
N. Mex.	6	7	3	11	12	10	-	-	-	-	-	-
Ariz.	19	6	45	38	9	15	-	-	-	-	-	-
Utah	-	1	5	8	-	1	-	-	-	-	-	-
Nev.	1	-	17	7	5	2	-	-	-	-	-	-
PACIFIC	7	14	144	402	103	146	-	2	-	-	2	2
Wash.	-	2	3	3	3	1	-	-	-	-	-	1
Oreg.	6	2	15	27	16	13	-	2	-	-	2	-
Calif.	-	5	119	365	83	128	-	-	-	-	-	1
Alaska	1	1	7	3	1	2	-	-	-	-	-	-
Hawaii	-	4	-	4	-	2	-	-	-	-	-	-
Guam	-	-	-	-	-	-	U	-	U	-	-	-
P.R.	-	-	-	30	1	17	U	-	U	-	-	-
V.I.	U	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.
*For imported measles, cases include only those resulting from importation from other countries.
† Of 19 cases among children aged <5 years, serotype was reported for 9 and of those, 0 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending February 10, 2001, and February 12, 2000 (6th Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000
UNITED STATES	243	327	1	10	51	34	394	546	-	2	4
NEW ENGLAND	23	17	-	-	-	2	105	144	-	-	3
Maine	-	1	-	-	-	-	-	4	-	-	-
N.H.	2	1	-	-	-	-	4	20	-	-	1
Vt.	-	1	-	-	-	1	16	27	-	-	-
Mass.	15	9	-	-	-	-	83	92	-	-	2
R.I.	-	1	-	-	-	-	-	-	-	-	-
Conn.	6	4	-	-	-	1	2	1	-	-	-
MID. ATLANTIC	26	24	-	-	3	2	12	39	-	-	1
Upstate N.Y.	11	6	-	-	1	2	12	22	-	-	-
N.Y. City	4	8	-	-	1	-	-	15	-	-	1
N.J.	10	4	-	-	-	-	-	-	-	-	-
Pa.	1	6	-	-	1	-	-	2	-	-	-
E.N. CENTRAL	18	62	1	1	6	5	63	119	-	2	-
Ohio	12	9	1	1	3	5	56	89	-	-	-
Ind.	-	6	-	-	-	-	1	3	-	-	-
Ill.	-	21	-	-	-	-	-	3	-	1	-
Mich.	6	16	-	-	3	-	5	5	-	1	-
Wis.	-	10	-	-	-	-	1	19	-	-	-
W.N. CENTRAL	17	23	-	1	4	-	18	15	-	-	-
Minn.	-	1	-	-	-	-	-	4	-	-	-
Iowa	4	3	-	-	1	-	2	4	-	-	-
Mo.	8	16	-	-	1	-	7	2	-	-	-
N. Dak.	-	1	-	-	-	-	-	-	-	-	-
S. Dak.	-	1	-	-	-	-	2	1	-	-	-
Nebr.	2	-	-	-	2	-	-	-	-	-	-
Kans.	3	1	-	1	-	-	7	4	-	-	-
S. ATLANTIC	51	46	-	1	5	2	18	26	-	-	-
Del.	-	-	-	-	-	-	-	-	-	-	-
Md.	11	4	-	1	1	-	5	11	-	-	-
D.C.	-	-	-	-	-	-	-	-	-	-	-
Va.	5	9	-	-	-	-	-	1	-	-	-
W. Va.	-	1	U	-	-	U	-	-	U	-	-
N.C.	10	10	-	-	-	1	9	4	-	-	-
S.C.	4	6	-	-	3	1	4	9	-	-	-
Ga.	7	7	-	-	-	-	-	-	-	-	-
Fla.	14	9	-	-	1	-	-	1	-	-	-
E.S. CENTRAL	21	16	-	-	1	1	9	22	-	-	-
Ky.	3	3	-	-	-	-	1	17	-	-	-
Tenn.	7	7	-	-	-	-	6	1	-	-	-
Ala.	8	5	-	-	1	1	2	3	-	-	-
Miss.	3	1	-	-	-	-	-	1	-	-	-
W.S. CENTRAL	19	35	-	-	7	1	3	3	-	-	-
Ark.	5	1	-	-	-	-	2	1	-	-	-
La.	8	16	-	-	-	-	-	1	-	-	-
Okla.	6	4	-	-	-	1	1	-	-	-	-
Tex.	-	14	-	-	7	-	-	1	-	-	-
MOUNTAIN	14	17	-	1	2	19	158	114	-	-	-
Mont.	-	-	-	-	-	-	-	-	-	-	-
Idaho	3	2	-	-	-	11	18	15	-	-	-
Wyo.	-	-	-	-	-	-	-	-	-	-	-
Colo.	-	3	-	-	-	-	-	74	-	-	-
N. Mex.	4	2	-	1	N	-	4	15	-	-	-
Ariz.	3	6	-	-	-	8	133	5	-	-	-
Utah	2	3	-	-	-	-	3	3	-	-	-
Nev.	2	1	-	-	2	-	-	2	-	-	-
PACIFIC	54	87	-	6	23	2	8	64	-	-	-
Wash.	5	4	-	-	-	2	5	1	-	-	-
Oreg.	10	13	N	N	N	-	3	8	-	-	-
Calif.	39	67	-	6	22	-	-	51	-	-	-
Alaska	-	-	-	-	-	-	-	2	-	-	-
Hawaii	-	3	-	-	1	-	-	2	-	-	-
Guam	-	-	U	-	-	U	-	-	U	-	-
P.R.	-	2	U	-	-	U	-	-	U	-	-
V.I.	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. - : No reported cases.

TABLE IV. Deaths in 122 U.S. cities,* week ending February 10, 2001 (6th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	680	509	114	28	16	13	68
Boston, Mass.	169	126	25	5	5	8	14
Bridgeport, Conn.	38	29	7	1	1	-	4
Cambridge, Mass.	17	14	2	-	1	-	1
Fall River, Mass.	30	25	4	-	1	-	-
Hartford, Conn.	74	46	18	5	2	3	5
Lowell, Mass.	35	28	6	1	-	-	5
Lynn, Mass.	16	12	2	2	-	-	1
New Bedford, Mass.	28	22	6	-	-	-	3
New Haven, Conn.	39	28	6	3	1	1	6
Providence, R.I.	56	42	8	3	2	1	-
Somerville, Mass.	12	9	3	-	-	-	1
Springfield, Mass.	48	29	13	4	2	-	8
Waterbury, Conn.	48	37	8	3	-	-	7
Worcester, Mass.	70	62	6	1	1	-	13
MID. ATLANTIC	2,430	1,722	475	151	43	38	155
Albany, N.Y.	58	36	16	3	2	2	7
Allentown, Pa.	19	15	4	-	-	-	1
Buffalo, N.Y.	94	65	18	4	2	5	7
Camden, N.J.	30	18	7	3	-	2	4
Elizabeth, N.J.	28	21	7	-	-	-	-
Erie, Pa.§	48	38	5	3	2	-	2
Jersey City, N.J.	44	33	7	4	-	-	-
New York City, N.Y.	1,240	875	239	86	21	19	78
Newark, N.J.	42	18	18	6	-	-	-
Paterson, N.J.	29	20	4	3	1	1	2
Philadelphia, Pa.	344	231	78	23	8	3	24
Pittsburgh, Pa.§	97	78	15	2	1	1	7
Reading, Pa.	19	17	2	-	-	-	-
Rochester, N.Y.	129	105	19	2	2	1	8
Schenectady, N.Y.	32	25	3	3	1	-	-
Scranton, Pa.§	35	30	4	1	-	-	4
Syracuse, N.Y.	81	57	18	2	2	2	7
Trenton, N.J.	46	29	10	4	1	2	4
Utica, N.Y.	15	12	1	2	-	-	-
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,894	1,342	358	121	34	39	110
Akron, Ohio	61	41	17	2	-	1	3
Canton, Ohio	43	33	8	2	-	-	3
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	149	110	23	6	4	6	9
Cleveland, Ohio	149	93	39	10	4	3	9
Columbus, Ohio	210	154	38	9	4	5	9
Dayton, Ohio	148	112	23	10	-	3	7
Detroit, Mich.	216	124	57	28	5	2	11
Evansville, Ind.	57	53	1	2	-	1	6
Fort Wayne, Ind.	63	51	8	3	1	-	4
Gary, Ind.	11	6	4	-	-	1	-
Grand Rapids, Mich.	33	24	6	-	-	3	3
Indianapolis, Ind.	224	140	52	17	7	8	11
Lansing, Mich.	32	23	8	-	-	1	1
Milwaukee, Wis.	145	104	28	7	4	2	8
Peoria, Ill.	52	35	6	9	1	1	7
Rockford, Ill.	63	47	7	8	1	-	4
South Bend, Ind.	54	44	9	1	-	-	5
Toledo, Ohio	118	95	14	5	2	2	8
Youngstown, Ohio	66	53	10	2	1	-	2
W.N. CENTRAL	924	695	140	45	20	24	75
Des Moines, Iowa	114	90	12	8	1	3	19
Duluth, Minn.	42	32	8	-	2	-	1
Kansas City, Kans.	48	30	12	2	2	2	4
Kansas City, Mo.	101	74	15	6	4	2	10
Lincoln, Nebr.	35	26	5	3	1	-	6
Minneapolis, Minn.	199	158	25	8	2	6	16
Omaha, Nebr.	97	76	15	4	-	2	6
St. Louis, Mo.	84	53	22	4	1	4	-
St. Paul, Minn.	100	84	11	2	3	-	8
Wichita, Kans.	104	72	15	8	4	5	5
S. ATLANTIC	1,424	937	280	137	40	29	95
Atlanta, Ga.	190	115	39	24	6	6	5
Baltimore, Md.	226	137	50	29	10	-	24
Charlotte, N.C.	119	83	21	7	3	5	7
Jacksonville, Fla.	144	87	29	19	5	4	11
Miami, Fla.	U	U	U	U	U	U	U
Norfolk, Va.	62	48	7	3	2	2	4
Richmond, Va.	65	41	15	7	1	1	6
Savannah, Ga.	71	45	16	7	2	1	2
St. Petersburg, Fla.	75	52	10	10	2	1	7
Tampa, Fla.	245	180	45	12	4	4	25
Washington, D.C.	200	122	48	19	5	5	4
Wilmington, Del.	27	27	-	-	-	-	-
E.S. CENTRAL	1,002	671	207	67	24	33	80
Birmingham, Ala.	212	145	41	17	7	2	17
Chattanooga, Tenn.	106	80	15	3	2	6	7
Knoxville, Tenn.	91	62	17	10	2	-	6
Lexington, Ky.	97	74	18	3	1	1	5
Memphis, Tenn.	258	154	63	21	4	16	24
Mobile, Ala.	49	32	8	6	2	1	-
Montgomery, Ala.	47	36	10	1	-	-	6
Nashville, Tenn.	142	88	35	6	6	7	15
W.S. CENTRAL	1,744	1,135	354	143	65	47	151
Austin, Tex.	88	55	21	8	3	1	8
Baton Rouge, La.	112	70	27	10	2	3	8
Corpus Christi, Tex.	74	57	11	4	1	1	7
Dallas, Tex.	228	132	56	23	7	10	19
El Paso, Tex.	109	78	13	5	7	6	3
Ft. Worth, Tex.	149	98	28	13	2	8	14
Houston, Tex.	413	235	100	46	26	6	45
Little Rock, Ark.	86	61	18	5	1	1	4
New Orleans, La.	U	U	U	U	U	U	U
San Antonio, Tex.	230	169	34	14	7	6	21
Shreveport, La.	105	69	22	6	5	3	14
Tulsa, Okla.	150	111	24	9	4	2	8
MOUNTAIN	1,115	787	213	79	24	12	88
Albuquerque, N.M.	138	91	32	13	2	-	11
Boise, Idaho	48	42	4	1	1	-	3
Colo. Springs, Colo.	57	38	12	5	1	1	4
Denver, Colo.	115	76	23	9	3	4	7
Las Vegas, Nev.	218	150	49	15	4	-	13
Ogden, Utah	36	26	6	2	2	-	6
Phoenix, Ariz.	168	108	29	19	7	5	14
Pueblo, Colo.	31	21	6	4	-	-	6
Salt Lake City, Utah	133	106	20	6	-	1	17
Tucson, Ariz.	171	129	32	5	4	1	7
PACIFIC	1,253	914	210	85	23	20	141
Berkeley, Calif.	19	15	2	2	-	-	2
Fresno, Calif.	103	66	27	7	-	3	8
Glendale, Calif.	U	U	U	U	U	U	U
Honolulu, Hawaii	101	67	24	7	2	1	11
Long Beach, Calif.	89	66	16	4	3	-	13
Los Angeles, Calif.	U	U	U	U	U	U	U
Pasadena, Calif.	24	19	3	1	-	1	3
Portland, Oreg.	129	103	17	9	-	-	9
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	200	137	32	18	7	5	19
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	233	179	32	11	6	5	31
Santa Cruz, Calif.	44	40	2	2	-	-	8
Seattle, Wash.	139	95	26	11	3	4	16
Spokane, Wash.	57	44	7	4	1	1	9
Tacoma, Wash.	115	83	22	9	1	-	12
TOTAL	12,466¶	8,712	2,351	856	289	255	963

U: Unavailable. -:No reported cases.

*Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

†Pneumonia and influenza.

§Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶Total includes unknown ages.

Contributors to the Production of the *MMWR* (Weekly)

Weekly Notifiable Disease Morbidity Data and 122 Cities Mortality Data

Samuel L. Groseclose, D.V.M., M.P.H.

State Support Team
Robert Fagan
Jose Aponte
Gerald Jones
David Nitschke
Scott Noldy
Carol A. Worsham

CDC Operations Team
Carol M. Knowles
Deborah A. Adams
Willie J. Anderson
Patsy A. Hall
Suzette A. Park
Felicia J. Perry
Pearl Sharp

Informatics

T. Demetri Vacalis, Ph.D.
Michele D. Renshaw
Erica R. Shaver

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